

Key Advantage

Notification of Changes to Your Member Handbook for July 1, 2002 Commonwealth of Virginia – Department of Human Resource Management

The following changes are part of your Key Advantage Member Handbook, #T20047 (6/00) as of July 1, 2002. Keep this and all previous notifications with your Member Handbook. You or your Benefits Administrator may view and print this Member Handbook, from the Department of Human Resource Management's Web site at www.dhrm.state.va.us/hbenefit.htm or from Trigon Blue Cross Blue Shield's site at <http://state.trigon.com>.

1) Inpatient Hospital Copayment changes from \$200 per confinement to \$300 per confinement.

Page 2 – Summary of Benefits
Page 14 – Inpatient services
Page 17 – Inpatient services, any setting

2) Outpatient Hospital Copayment, including emergency room, changes from \$75 per Visit to \$100 per Visit.

Page 2 – Summary of Benefits
Page 14 – Outpatient services
Page 17 – Outpatient Hospital

3) Primary Care Physician (PCP) Copayment changes from \$15 per PCP Visit to \$20 per PCP Visit.

Page 2 – Summary of Benefits
Page 20 – Home health services
Page 26 – Maternity Services, and Other Outpatient care
Page 28 – Hospice care services
Page 43 – Colonoscopy (under Optional Expanded Benefits)

4) Specialist Copayment changes from \$25 per Specialist Visit to \$30 per Specialist Visit.

Page 2 – Summary of Benefits
Page 14 – Physical Therapy
Page 17 – Professional Services, except Employee Assistance
Page 20 – Home health services
Page 26 – Maternity Services, and Other Outpatient care
Page 27 – Chiropractic services
Page 28 – Hospice care services
Page 38 – Summary of Benefits (under Optional Expanded Benefits)
Page 43 – Colonoscopy (under Optional Expanded Benefits)
Page 45 – Routine vision examinations (under Optional Expanded Benefits)

5) Outpatient Prescription Drug Copayments change as follows:

Network Retail Pharmacies

- Up to a 34-day supply Changes from \$15 to \$17
- A 35- to 90-day supply Changes from \$30 to \$34

- Mail Service Pharmacy
- Up to a 90-day supply

Changes from \$23 to **\$25**

Page 2 – Summary of Benefits
Page 30 – Copayments

6) The Routine Vision benefit under the Optional Expanded Benefits changes as follows:

Routine eye examination	Copayment changes from \$25 to <u>\$30</u>
Eyeglass frames	Plan payment changes from \$50 to <u>\$75</u>
Single vision lenses	Plan payment changes from \$35 to <u>\$50</u>
Bifocal lenses	Plan payment changes from \$50 to <u>\$75</u>
Trifocal lenses	Plan payment changes from \$70 to <u>\$100</u>
Contact lenses	Plan payment is unchanged at \$100

Page 38 – Summary of Benefits
Page 45 – Reimbursement, Copayments

7) Under Chiropractic Services, spinal manipulation and other manual intervention visits are limited to \$500 per calendar year.

Page 2 – Summary of Benefits
Page 27 – Chiropractic services

8) An appeal to the director of the Department must entail a liability of at least \$300 to qualify for review by an outside impartial health entity, as follows:

Reviews for treatment authorizations or medical claims that have been denied will be sent to an impartial health entity. The impartial health entity shall examine the final denial of claims or treatment authorizations to determine whether the decision is objective, clinically valid, and compatible with established principles of health care. The decision of the impartial health entity shall (i) be in writing, (ii) contain findings of fact as to the material issues in the case and the basis for those findings, and (iii) be final and binding if consistent with law and policy. Medical appeals accepted into the review process must entail a liability of at least \$300 to the appellant or covered family member.

Page 7 – Appeals

9) Outpatient Prescription Drug Program Special Limits, number 1) under the 34-day supply from a retail pharmacy, the following limits are removed: 120 units or 500 milliliters of the drug, and two 10-milliliter vials of insulin.

Page 29 – Special Limits

10) Outpatient Prescription Drug Program Special Limits, number 7) is replaced as follows:

7) Prior authorization is required for certain medications. You will be notified in writing when a prescription is denied for coverage. Your physician will be notified of both approval and denial decisions.

Page 29 – Special Limits

11) Outpatient Prescription Drug Program Special Limits, number 8) i. – limitation removed.

Page 29 – Special Limits

12) Under Major Medical Services, number 9) Dental services is replaced as follows:

Dental services and dental appliances a provider furnishes are covered when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia. Medically necessary dental services, resulting from an accidental injury while covered under the plan, are eligible for reimbursement if a plan of treatment from the dentist or oral surgeon is submitted to Trigon within 60 days of the date of the injury and subsequently approved. Dental services are also covered when required to diagnose or treat an accidental injury to the teeth if the accident occurs while the insured is covered under the plan. These services and appliances are covered for adults if rendered within a two-year period after the accidental injury.

The above two-year restriction may be waived for children under age 18. Actual treatment may be delayed if tooth/bone maturity is in question and standard industry protocols are followed. However, a treatment plan must be filed within 6 months of the accident and treatment must be completed within two years of active treatment commencement and prior to age 20. For the waiver to be granted, continuous coverage under the plan is required.

Major Medical Services include the repair of dental appliances damaged as a result of accidental injury to your jaw, mouth, or face. Injury as a result of chewing or biting will not be considered an accidental injury.

Page 34 – Services Which Are Eligible for Reimbursement

13) Exclusions, number 36) is replaced as follows effective October 1, 2002:

Your coverage does not include benefits for services or supplies if they are deemed not **medically necessary** as determined by Trigon at its sole discretion.

However, if you receive inpatient or outpatient services that are denied as not medically necessary, or are denied for failure to obtain the required pre-authorization or primary care physician referral, the following professional provider services that you receive during your inpatient stay or as part of your outpatient services will not be denied under this exclusion in spite of the Medical Necessity denial of the overall services:

For Inpatients – 1) Services that are rendered by professional providers who do not control whether you are treated on an inpatient basis, such as pathologists, radiologists, anesthesiologists, and consulting physicians.

2) Services rendered by your Attending Provider other than inpatient evaluation and management services provided to you. Inpatient evaluation and management services include routine visits by your Attending Provider for purposes such as reviewing patient status, test results, and patient medical records. Inpatient evaluation and management visits do not include surgical, diagnostic, or therapeutic services performed by your Attending Provider.

For Outpatients – Services of pathologists, radiologists and anesthesiologists.

Page 48 – Exclusions

14) Language regarding the requirement to contact your PCP within 48 hours of an emergency admission is added as follows:

Your PCP must be contacted within 48 hours of treatment for a life-threatening emergency. The contact may be made by you, the admitting physician, a family member or a friend.

Page 12 – Conditions for Reimbursement
Page 24 – Conditions for Reimbursement
Page 60 – Definitions, Emergency Services

- 15) The section in the Code of Virginia pertaining to the State Health Benefits Program was re-codified effective October 1, 2001. As a result, the section reference is now §2.2-2818.

Page 71 – Statutory Benefits

- 16) The Eligibility, Enrollment and Plan or Membership Changes section, is replaced as follows:

Newly Hired Employee: Coverage for a newly hired employee is effective the first of the month following receipt of notice of an election. Employees hired on the first working day of the month who submit notice that day have coverage beginning the first of the month they were hired. Election to participate in the health benefits program must be made within 31 days from the date of hire.

Open Enrollment: The annual Open Enrollment period is the time when you may make Plan or membership changes.

Qualifying Mid-Year Events (Life Events): Notice of membership changes or enrolling for coverage due to these events must be given within 31 days of the event. Changes take effect the first of the month after notice of the election is received. If notice is given on the first day of the month, the election is effective that day. Other exceptions are birth, adoption, placement for adoption (changes are effective the first of the month of the event), and termination of ineligible members (changes are effective the last day of the month in which the Participant loses eligibility). Following is a summary of these qualifying mid-year events. Contact your Benefits Administrator if you have questions.

Change in Your Employment Status

- Begins/ends full-time employment (includes rehire after 30 days)
- Begins/ends leave without pay
- Begins/ends family medical leave
- Begins Virginia Sickness and Disability Program long-term disability (not working)
- Begins retirement
- Enrolls in single membership if previously waived coverage

Change in Your Marital Status

- Marriage, divorce or death of a spouse

Change in Your Number of Eligible Dependents

- Birth or adoption (Note: The Department of Human Resource Management must review all pre-adoptive placements to verify eligibility)
- Death of a covered child
- Covered child is no longer eligible for coverage under your plan (exceeds plan's age limit, marries, becomes self-supporting, etc.)
- Court order to cover a child
- Department of Social Services order to cover a child

Changes Affecting Your Dependent(s) Employment

- Spouse begins/ends leave without pay
- Spouse or covered child begins employment/spouse or eligible child ends employment
- Spouse switched from full-time to part-time employment or vice versa
- Eligible child switched from full-time to part-time employment or vice versa

Other Changes Affecting Your Dependent(s)

- Annual enrollment or change allowed under another employer's plan
- Gains eligibility for Medicare or Medicaid
- Loses eligibility for Medicare, Medicaid or another government-sponsored plan

Changes Due to Special Circumstances

- Permanently moves in or out of a plan's service area (*Note: In addition to a change in membership, this event may also allow a plan change.*)
- Special (HIPAA) enrollment due to loss of coverage
- You or your dependent permanently changed residence, affecting eligibility for the State program
- A court has required that another party cover your children

Payment of Premiums: During Open Enrollment, employees may choose to pay their health benefits premiums on a pre-tax or after-tax basis. The election will be in effect during the fiscal year, from July 1 through the following June 30.

Retirement: State retiree coverage begins on the first day of the first full month of retirement, regardless of the date of enrollment, as long as enrollment is completed within 31 days of the retirement date. Coverage for a retiree returning from participation as a dependent under the State Health Benefits Program will begin on the first of the month after the loss of active coverage, if application is received within 31 days of the loss.

Page 69 – Eligibility

The following table is an update to the Summary of Benefits on page 2 of your Member Handbook. **Bold, italicized and underscored** text represents a change from the original July 2000 Member Handbook.

SUMMARY OF KEY ADVANTAGE BENEFITS ***Effective July 1, 2002***

	Covered Services	In-Network You Pay
Inpatient Hospital	365 days per Confinement in semi-private room, or intensive care unit. Includes ancillary services.	<u>\$300</u> per Confinement
Outpatient Hospital	Facility charge for outpatient department of a Hospital or Hospital emergency room	<u>\$100</u> per Visit (waived if admitted)
Skilled Nursing Facility	180 days per Confinement in Network Skilled Nursing Facility	\$0
Home Health Care	90 Visits per calendar year	<u>\$20</u> per PCP Visit; <u>\$30</u> per specialist Visit
Professional Services	<ul style="list-style-type: none">• Inpatient Physician care• Outpatient Physician Visit in office or Hospital<ul style="list-style-type: none">▪ Primary care▪ Specialty care▪ Maternity Services	\$0 <u>\$20</u> <u>\$30</u> <u>\$20</u> per PCP Visit; <u>\$30</u> per specialist Visit
Physical/Speech/ Occupational Therapy	<ul style="list-style-type: none">• Physical Therapy – authorized in advance by PCP• Speech and Occupational Therapy	<u>\$30</u> per specialist Visit
Chiropractic Services	Plan pays \$500 per calendar year for spinal manipulation <u>and other manual intervention visits</u>	<u>\$30</u> per specialist Visit
Diagnostic Tests and Laboratory Services	Physician office, clinical reference lab, or outpatient hospital	10% AC*
Outpatient Prescription Drugs (Mandatory generic)	<ul style="list-style-type: none">• Retail up to 34-day supply• Retail 35-90-day supply• Mail service up to 90-day supply <i>(If You choose the brand when a generic is available, You pay Copayment plus 100% of the difference between the generic drug AC and the brand drug AC.)</i>	<u>\$17</u> <u>\$34</u> <u>\$25</u>

	Covered Services	In-Network You Pay
Dental	Plan pays \$1,200 per member per calendar year <ul style="list-style-type: none"> Diagnostic and preventive services Primary services <i>(Also see Key Advantage Optional Expanded Benefits section if You have selected this option.)</i>	\$0 20% AC
Vision	<i>Under the Optional Expanded Benefits section:</i> Once every 24 months: Routine eye examination Eyeglass frames (one pair) Eyeglass lenses (one pair) <ul style="list-style-type: none"> Single vision lenses, or Bifocal lenses, or Trifocal lenses OR Contact lenses (any type)	\$30 per specialist visit Remaining cost after Plan pays \$75 Remaining cost after Plan pays \$50 Remaining cost after Plan pays \$75 Remaining cost after Plan pays \$100 Remaining cost after Plan pays \$100
Preventive Care and Immunizations	<ul style="list-style-type: none"> Well baby care Visit <ul style="list-style-type: none"> Laboratory services Immunizations Annual routine gynecological Visit <ul style="list-style-type: none"> Annual Pap smear Mammography screening and reading Annual PSA test Digital rectal examination 	\$20 per PCP Visit; \$30 per specialist Visit 10% AC \$0 \$20 per PCP Visit; \$30 per specialist Visit 10% AC 10% AC 10% AC \$20 per PCP Visit; \$30 per specialist Visit
Emergency Services for Life-Threatening Conditions	<ul style="list-style-type: none"> Hospital emergency room Physician care Diagnostic x-rays, laboratory services, etc. 	\$100 per Visit (waived if admitted) \$30 per specialist Visit 10% AC
Mental Illness and Substance Abuse Services	<ul style="list-style-type: none"> Outpatient Visit – authorized in advance of care; up to 50 Visits for non-biologically based mental illness Outpatient Hospital Inpatient and partial days of care; up to 30 days per Benefit Period; 90 day lifetime maximum for non-biologically based mental illness 	\$30 per Visit \$100 per Visit \$300 per Confinement
Annual Out-of-Pocket Expense Limit	Plan pays 100% AC once limit is met for covered services. (Certain expenses do not count toward this limit as defined in the Key Advantage Member Handbook on page 9.)	Calendar year limit: <ul style="list-style-type: none"> \$1,000 single \$2,000 employee plus one \$1,000 per family member, up to \$3,000 total per family

*Allowable Charge (AC): See Definitions section.

Your Member Handbook may be printed at any time from the following Web sites:
www.dhrm.state.va.us/hbenefit.htm or <http://state.trigon.com>.